SBAR Handover

Nursing

The four-part structure that turns a worry into a communicable clinical message.

Prepare it on paper first. Thirty seconds of writing buys a clear call.

1. **Situation**
   Who you are, who the patient is, and the problem in one line.

2. **Background**
   Admission reason, relevant history, current treatment, allergies.

3. **Assessment**
   Your observations, your early warning score, what you think it is.

4. **Recommendation**
   What you want, by when, and what you will do meanwhile.

Educational reference. SBAR is a communication frame, not an escalation policy — local protocol sets who to call and how fast.